

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-024971

STATE FILE NUMBER

Registration District No. 179 Primary Registration District No. 4292 Registrar's No. 107

FILED JUL 10 1963

1. PLACE OF DEATH a. COUNTY Lincoln		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lincoln	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Winfield		c. CITY OR TOWN Winfield	
Length of stay in 1b 11 years		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Residence		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) ORIN SMITH CARTER			4. DATE OF DEATH July 3, 1963		
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-1-03	9. AGE (last birthday) 59	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electric Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Missouri Edison Co.		11. BIRTHPLACE (City and state or country) Troy, Mo.	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Smith Miller Carter		13b. MOTHER'S MAIDEN NAME Elizabeth Jamison	
14. NAME OF HUSBAND OR WIFE Alic (nee Hamlett)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT wife		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH Immediate	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 12:15		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION Winfield, Mo.		20g. COUNTY Lincoln		20h. STATE Missouri	
21. I attended the deceased from _____ to _____ and last saw him/her alive on July 2, 1963		22. SIGNATURE (Degree or title) Dr. Charles E. Leek		22b. ADDRESS Winfield, Mo.	
22c. DATE SIGNED 7-4-63		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 5, 1963	
23c. NAME OF CEMETERY OR CREMATORY City Cemetery		23d. LOCATION (City, town, or county) Troy, Missouri		23e. STATE Missouri	

24. FUNERAL DIRECTOR Ricks Funeral Home		25. DATE RECD. BY LOCAL REG. 7-6-1963		26. REGISTRAR'S SIGNATURE Charlotte Leek	
ADDRESS Elsberry, Mo.		25. DATE RECD. BY LOCAL REG. 7-6-1963		26. REGISTRAR'S SIGNATURE Charlotte Leek	

(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

JUL 12 1963

JUL 18 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4012
P. O. Address Eschberg, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.